PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY

05/17/2011 14:33 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER

8655945739

HEALTH CARE FACILITY

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PRINTED: 05/17/2011 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION

01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

445383

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

05/09/2011

COMPLETION

DATE

63/11

UNITED REGIONAL MEDICAL CENTER NURSING HOME

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

STREET ADDRESS, CITY, STATE, ZIP CODE 1001 MCARTHUR DRIVE MANCHESTER, TN 37355

NFPA 101 LIFE SAFETY CODE STANDARD K 029 SS=D

One hour fire rated construction (with % hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors.. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the hazardous areas.

The findings include:

Observation of the mechanical room by room 611 and the boiler room on 5/9/11 at 10:30 AM, revealed penetrations in the walls and in the ceilings.

This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 5/9/11. NFPA 101 LIFE SAFETY CODE STANDARD

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are

K29 K 029

A. BUILDING

B. WING

ID PREFIX

TAG

On 5/13/11, the Maintenance Director repaired the penetrations in the mechanical room by room 611. The Maintenance Director will have the penetrations repaired in the boiler room by 6/3/11. All residents have the potential to be affected in the event of a fire. The Maintenance Director or his designee will be responsible for checking all areas of the facility to ensure all areas are properly maintained and free of any penetrations in the walls or ceilings. The Maintenance Director or his designee will monitor this by random observation throughout the facility five times per week times four week and then weekly to ensure compliance. The Maintenance Director will report audit findings to the Administrator monthly. The results of these audits will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and is composed of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Maintenance Director and others as indicated.

K 050

K50

On 5/25/11, the Maintenance Director will also conduct an in-service for all nursing home staff on the policy and procedures to be followed in the event of a fire. The

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

(X8) DATE

6311

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

K 050

SS=D

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/SUPPLIER 445393 NAME OF PROVIDER OR SUPPLIER UNITED REGIONAL MEDICAL CENTER NURSING HOME		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU A BUILDING 01 - MU B. WING		UCTION AIN BUILDING 01	FORM APPROV OMB NO. 0938-0: (X3) DATE SURVEY COMPLETED	
		STREET ADDRES		S, CITY, STATE, ZIP CODE UR DRIVE	05/09/2011		
(X4) ID PREFIX TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRO (EACH	R, TN 37355 WIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU REFERENCED TO THE APPRO DEFICIENCY)		COMPLETIC DATE
C 054 N SS=D Al ac ma with Ba faci	qualified to exercise conducted between announcement may alarms. 19.7.1.2 This STANDARD is Based on observation facility failed the fire of the findings include: Observation during the fire of the findings include: Observation during the fire of the fire alarm system. This finding was acknown the fire alarm system. The finding was acknown the fire alarm system. The finding was acknown the fire of the corridation of the corridatio	leadership. Where drills are 9 PM and 6 AM a coded be used instead of audible be used instead of audible not met as evidenced by: not, it was determined the drill. e fire drill on 5/9/11 at 10:32 f did not announce the code of fire, and failed to activate owledged by the fied by the Director of the conference on 5/8/11. TY CODE STANDARD ectors, including those on devices, are approved, and tested in accordance specifications. 9.8.1.3 met as evidenced by: it was determined the the smoke detector.	K 054	weeks and a All resident affected in the Mainter will be respected for the fire drawn of the QA Composed of The QA Composed of Assistant DO: Director, Social Maintenance of the fire drawn of t	ce Director will be responsive drills weekly times then at least monthly. It is have the potential to be the event of a fire. It is more than 3 feet for ensuring that are greater than 3 feet fire. This will be done by rounds throughout the crompliance of a fire. The Maintenance Director of the potential to be the potential	four e signee all e results the enance will be erly. ion ted. nd is , edical ector, or by rom	3/11

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HEALTH CARE FACILITY

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/ OIA! EME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRU		(X3) DATE S	SURVE
		445383	A. BUILD B. WING	7.	IN BUILDING 01	COMPL	ETED
NAME OF	PROVIDER OR SUPPLIER					05/0	09/201
UNITED	REGIONAL MEDICAL	CENTER NURSING HOME		1001 MCARTHU	CITY, STATE, ZIP CODE IR DRIVE		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		MANCHESTE			
TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFIX TAG		INDER'S PLAN OF CORRECTIVE ACTION SHI EFERENCED TO THE APP DEFICIENCY)		COMP
K 054	Continued From page 2 was installed within 3 feet of the air diffuser.		K 054	Maintenanc completed n	e Director. This audi	t will be	
	This finding was ack	DOWledged by the		Committee	ommittee quarterly. will make recommend	The QA	
K 062 SS≃D	Maintenance at the	rified by the Director of exit conference on 5/8/11. ETY CODE STANDARD	K 062	noncompliar Committee r	ction plan if areas of ice are noted. The Q neets quarterly and is	A	
,	Required automatic s continuously maintair condition and are insi	prinkler systems are		MDS Coordi Services, Ac	nstrator, DON, Assis nator, Medical Direc tivity Director, Maint	tant DON,	
1.3	periodically. 19.7.6 25, 9.7.5	, 4.6.12, NFPA 13, NFPA		Director and	others as indicated.		
f		ot met as evidenced by: is, it was determined the in the sprinkler system.					
5	bservation of the sun	ply room by room 506 on es stored within 18 inches			: to		
TI Ad M	his finding was acknown and verification and verification and the exit	Moderal by the			ī		
SS=D Ele	ectrical wiring and equ	lipment is in accordance Electrical Code. 9.1.2	K 147	St /	34		
1	is STANDARD is not sed on observations, ility failed to maintain t	IT MATERIAL PROPERTY I AL		w.			a

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FACILITY

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PRINTED: 05/17/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROMDER/SUPPLIER/CLIA (X2		LTIPLE CONSTRUC			<u>10. 0938-039</u>	
		IDENTIFICATION NUMBER:	A. BUILD	DING 01 - MAI	IN BUILDING 01		(X3) DATE SURVEY COMPLETED 05/09/2011	
		445383	B. WING			05/		
		L CENTER NURSING HOME	s	TREET ADDRESS, 1001 MCARTHU MANCHESTE	CITY, STATE, ZIP COD IR DRIVE R. TN 37355	E .	09/2011	
(X4) ID PREFIX TAG	CEACH DEFINIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROV (EACH (VIDER'S PLAN OF CORP CORRECTIVE ACTION S EFERENCED TO THE A DEFICIENCY)	SHOURD BE	COMPLETION DATE	
K 054		age 2 3 feet of the air diffuser.	K 05	4		100.		
K 062 SS=D	This finding was ac Administrator and v Maintenance at the NFPA 101 LIFE SA Required automatic continuously mainta condition and are in	knowledged by the rerified by the Director of exit conference on 5/9/11. FETY CODE STANDARD sprinkler systems are	K 062	The supplies of the sprink room 506 we All residents	stored with-in the ler heads in the store are removed 5/19/11 have the potential to e event of a fire du	rage room by	пЕЫ	
< 147 SS=D	facility falled to main facility falled to main The findings include: Observation of the state of the spinkler. This finding was ackradministrator and very Maintenance at the expension of the spinkler. The finding was ackradministrator and very Maintenance at the expension of the spinkler. The finding was ackradministrator and very Maintenance at the expension of the spinkler of	upply room by room 506 on olies stored within 18 inches nowledged by the rifled by the Director of at conference on 5/9/11. ETY CODE STANDARD equipment is in accordance and Electrical Code. 9.1.2		sprinklers no properly if su inch rule. All employee regarding the system. The Administ monitor the coeffectiveness or random walking facility five timenitor the 18 are identified roccur weekly to results of these QA Committee will develop an actinoncompliance Committee con	t being able to function pplies are stored able so will be in-serviced 18-inch rule for the store of this action by performed the service action to each of this action by performed the service action to grounds throughous per week times andom walking rounds will be reported audits will be reported to plan if areas of are noted. The QA sists of the Adminitration and the polarical services are noted.	d 5/25/11 e sprinkler e will ensure efforming the 4 weeks to either issues ends will e. The erted to the d ations and		
1 0	rascu on observation	ot met as evidenced by: is, it was determined the in the electrical system.		DON, Assistan Coordinator, M	t Administrator, Mi edical Director, So ity Director and oth	DS cial		

FORM CMS-2567(02-99) Previous Versions Obsolote

Event ID: OZPF21

indicated. Facility ID: TN1601

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2011 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 445383 NAME OF PROVIDER OR SUPPLIER 05/09/2011 STREET ADDRESS, CITY, STATE, ZIP CODE UNITED REGIONAL MEDICAL CENTER NURSING HOME 1001 MCARTHUR DRIVE MANCHESTER, TN 37355 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION ID PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION TAG DATE K 147 Continued From page 3 K 147 K147 43111 The findings include: The equipment blocking the electrical panels in the kitchen dry storage room was Observation of the kitchen dry storage room on 5/9/11 at 11:00 AM, revealed the electrical panel removed on 5/9/11 by maintenance was blocked with equipment. personnel. All residents have the potential to be This finding was acknowledged by the affected in the event of a fire or electrical Administrator and verified by the Director of outage. maintenance at the exit conference on 5/9/11. Maintenance employees will be in-serviced on 5/25/11 regarding properly maintaining the electrical system. Administrator or their designee will monitor the corrective action to ensure the effectiveness of this action by performing random walking rounds throughout the facility five times per week times four weeks to ensure no electrical panels are blocked. If no further issues are identified random walking rounds will occur weekly to ensure compliance. The results of this monitoring will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.

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Event ID: QZPF21

Facility ID: TN1601

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